Billing Instructions
For
Impact Plus
P. T. – 29

Kentucky Department for Medicaid Services (DMS)

Unisys Fiscal Agent

August 11, 2003 (DMS Revised)

TABLE OF CONTENTS

NUMBER DESCRIPTION CHAPTER-PAGE

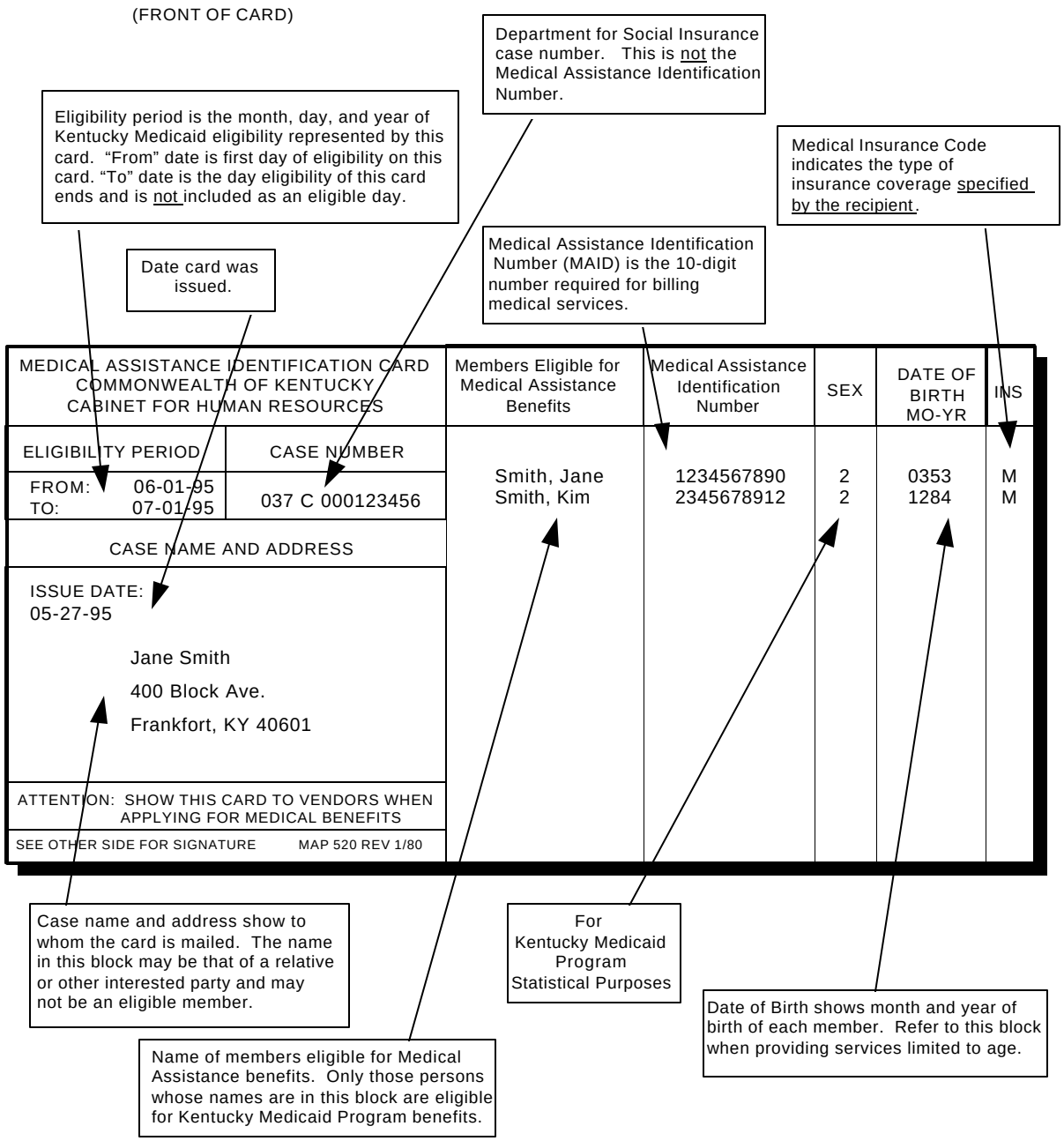
1. GENERAL INFORMATION

1.1. RECIPIENT ELIGIBILITY

The primary identification card for Medicaid-eligible persons is the Kentucky Medical Assistance Identification Card (MAID). The card is issued monthly and usually reflects only one month of eligibility. However, some MAID cards may be issued for a partial month or for a period longer than one month. **The card should be viewed each time the recipient is seen to verify eligibility**. The provider should also check the card for correct information, such as the recipient's name and MA ID number, any third party coverage, any limitations of Medicaid coverage and to verify that the card is current for the date of service. Payment can **not** be made for services provided to ineligible persons. Copies of Medicaid cards follow.

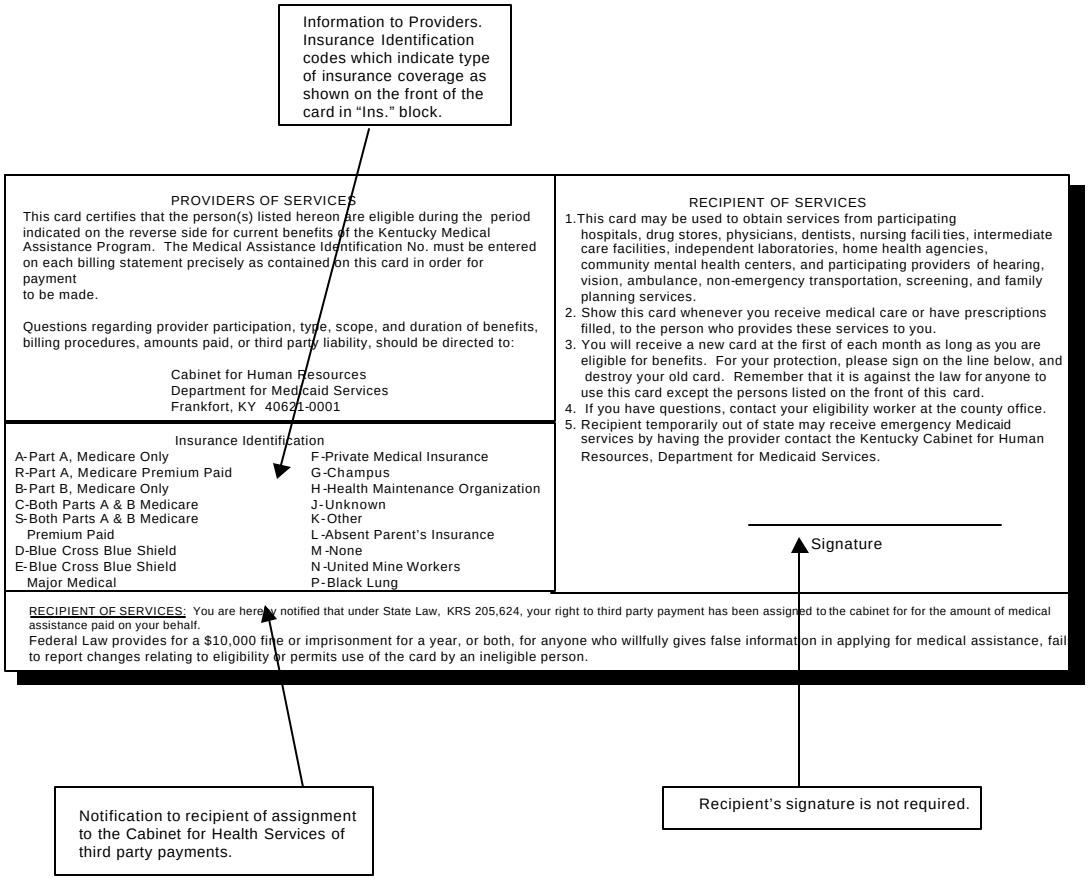
1.2. KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (MAID) CARDS

1.2.1. REGULAR CARD

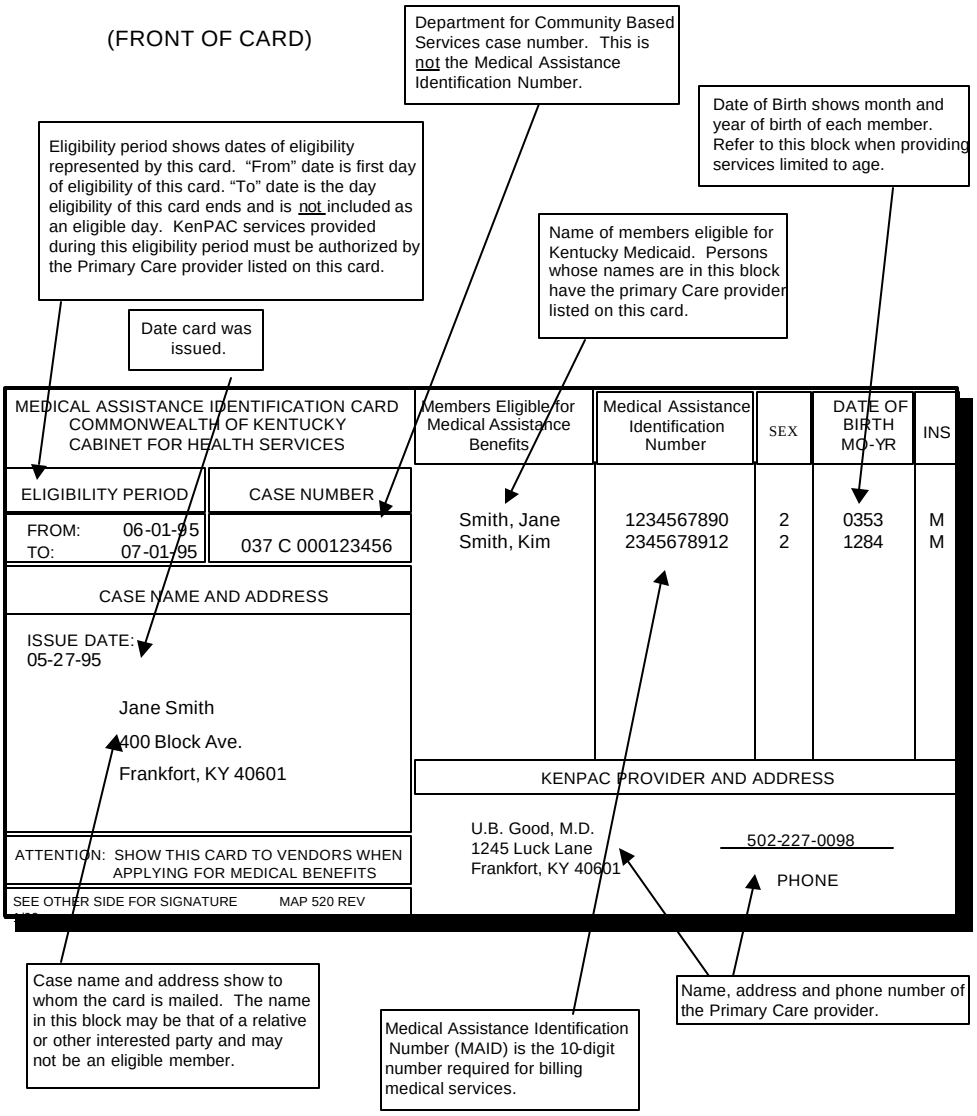


WHITE CARD

1.2.2. BACK OF REGULAR CARD

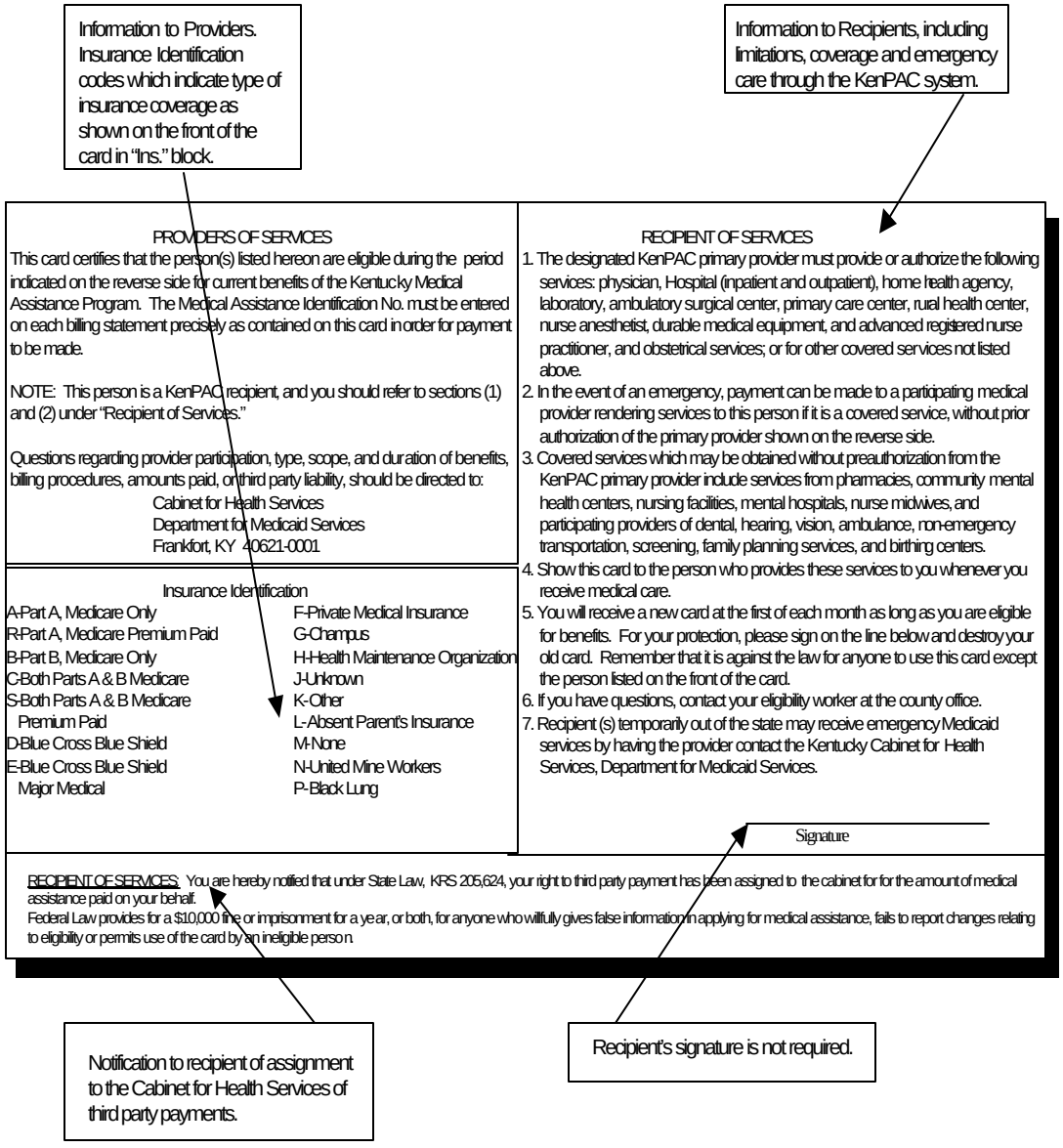


1.2.3. KENPAC MAID CARD



GREEN CARD

1.2.4. BACK OF KENPAC MAID CARD



1.3. VERIFICATION OF RECIPIENT ELIGIBILITY

This section discusses:

- Methods for verifying eligibility
- Information available through VREV
- How VREV processes calls.

1.3.1. OBTAINING ELIGIBILITY AND BENEFIT INFORMATION

Eligibility and benefit information is available to providers via the following:

- Voice Response Eligibility Verification (VREV)
- A human operator.

1.3.2. VOICE RESPONSE ELIGIBILITY VERIFICATION (VREV)

Unisys maintains a Voice Response Eligibility Verification (VREV) system that provides recipient eligibility verification, coverage limitations, third-party resource information, lock-in information, KenPAC information and claim status. Provider check amount information is also available through VREV.

The VREV system generally processes calls in the following sequence:

1. Greet the caller and prompt for mandatory provider ID.
2. Prompt the caller to select the type of inquiry desired (eligibility, check amount, or claim status).
3. Prompt the caller for the dates of service (enter four digit year, e.g., MMDDCCYY).
4. Respond by providing the appropriate information for the requested inquiry.
5. Prompt for another inquiry.
6. Conclude the call.

The VREV system contains the following recipient information:

- Eligibility verification
- KenPAC and Lock-In provider information
- Third-party liability information
- Provider check-write information
- Claim status information
- Medicare Part A and B coverage.

This system provides a fast-path mode that permits a provider to take a short path to information by keying the appropriate responses to prompts (such as provider ID or identification) as soon as each prompt begins. This greatly increases the speed of the inquiry. The number of inquiries is limited to five (5) per call. The VREV spells the recipient name and announces the dates of service to ensure accuracy of responses. The check amount data is accessed through the VREV voice menu. The provider file is accessed to obtain up to the last three (3) processing check dates and check amounts.

The telephone number (for use by touch-tone phones only) for the VREV is **800-807-1301**. If you have a rotary telephone, VREV is not available.

1.3.3. TELEPHONE OPERATOR VERIFICATION

The provider can also verify eligibility by contacting the Kentucky Department for Medicaid Services, Recipient Eligibility at 502-564-5020 or Unisys Provider Relations at **800-807-1232**.

NOTE: Impact Plus providers cannot use Tax Identification numbers to access the Voice Response Eligibility Verification (VREV) system. You must use the provider ID listed on your prior authorization form in the right hand corner.

1.3.4. VOICE RESPONSE CONVERSATION CHART

HOW TO USE UNISYS VOICE RESPONSE IF YOU HAVE RECIPIENT NAME AND DOB. DIAL 1800-807-1301

CHOOSE THE FOLLOWING PROMPTS…*1, ENTER PROVIDER I.D., *1, *5, *2, ENTER FIRST 4 DIGITS OF FIRST NAME (MUST USE CONVERSION CHART BELOW), ENTER FIRST 5 DIGITS OF LAST NAME, *2 (ENTER DOB IN MMDDCCYY FORMAT) , ENTER 1 IF MALE, 2 IF FEMALE, THEN ENTER DATE OF SERVICE *TWICE.*

THE SYSTEM WILL THEN GIVE THE ENTIRE NAME AND RECIPIENT MEDICAID NUMBER AS WELL AS ANSWER THIRD PARTY LIABILITY QUESTIONS, CHECK KENPAC AND OTHER INFO REGARDING ELIGIBILITY.

A 21	H 42	O 63	V 83
B 22	I 43	P 71	W 91
C 23	J 51	Q 11	X 92
D 31	K 52	R 72	Y 93
E 32	L 53	S 73	Z 12
F 33	M 61	T 81	SP *
G 41	N 62	U 82	END #

2. GENERAL BILLING INSTRUCTIONS

2.1. GENERAL INSTRUCTIONS

The Department for Medicaid Services is mandated by the Centers for Medicare & Medicaid Services (CMS) to use standard claim forms, such as the HCFA-1500 (12/90) claim form. You may bill either on paper or electronically. **Note, however, any claim requiring an attachment must be submitted on paper.**

2.2. IMAGING

All paper claims will be imaged. Imaging is taking a picture of the claim and using that picture during claims processing. The major objectives of the imaging technology are faster and more accurate claim processing, improved customer and provider service, and reduced storage requirements. This state of the art technology will streamline Medicaid claims processing, as well as provide efficient tools for claim resolution, inquiries, and attendant claim related matters. Considerable gains in productivity and data accuracy will be achieved with the Unisys Imaging Solution implemented. Listed are a few guidelines for original claims, **as well as claims that are being resubmitted**, to ensure accurate readability:

- USE BLACK INK ONLY.
- Do not use glue.
- Do not use more than one staple per claim.
- Press hard to guarantee strong print density if claim is not typed or computer generated.
- Do not use white-out or shiny correction tape.
- Do not send attachments smaller than the accompanying claim form.

2.3. OPTICAL CHARACTER RECOGNITION

Optical Character Recognition (OCR) eliminates human intervention by sending the information on the claim directly to the processing system, bypassing data entry. OCR is used for computer generated or typed claims only. Information obtained mechanically during the imaging stage will not have to be manually keyed, thus reducing claim processing time. Information on the claim must be contained within the fields in order for the text to be properly read by the scanner.

3. COMPLETION OF HCFA-1500 (12/90)

3.1. PAPER CLAIM FORM

The HCFA-1500 (12/90) claim form is used to bill services for Impact Plus. A copy of a completed claim form is shown on the following page.

Providers may order paper HCFA-1500 (12/90) claim forms from the:

U.S. Government Printing Office
Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 15250-7954

Telephone: 1-202-512-1800

APLE
THIS
EA

HEALTH INSURANCE CLAIM FORM

MEDICARE | MEDICAID | CHAMPUS | CHAMPVA | GROUP HEALTH PLAN | FECA BLK LUNG | OTHER

( ) (Medicare #) | (X) (Medicaid #) | ( ) (Sponsor's SSN) | ( ) (VA File #) | ( ) (SSN or ID) | ( ) (SSN) | ( ) (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

PATIENT'S NAME (Last Name, First Name, Middle Initial): JACKSON WILLIAM D

3. PATIENT'S BIRTH DATE MM DD YY | SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

ITY | STATE

8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

IP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO: *IF APPLICABLE*

11. INSURED'S POLICY GROUP OR FECA NUMBER

OTHER INSURED'S POLICY OR GROUP NUMBER: 4000500000

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M F

OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. AUTO ACCIDENT? PLACE (State) YES | NO

b. EMPLOYER'S NAME OR SCHOOL NAME

EMPLOYER'S NAME OR SCHOOL

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO — *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM

. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information cessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED

. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SEVICES MM DD YY FROM TO

. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO $ CHARGES

. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)

3. V222

3

4

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

. A DATE(S) OF SERVICE FROM DD YY MM TO DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E	$ CHARGES	G DAYS OR UNITS	H EPSDT FAMILY PLAN	I EMG	J COB	K RESERVED FOR LOCAL USE
01603	99		T2023		1	300 00	1				
01603	99		H2019		1	17 16	14				

. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO. 610001011-001

27. ACCEPT ASSIGNMENT? YES | NO

28. TOTAL CHARGE $ 317 16

29. AMOUNT PAID $

30. BALANCE DUE

L. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)

John Ball 10/25/03

NED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE#
We Care
100 Easy St.
Anytown, KY 40601

PIN 291OR 29200000 Grp# 29900016

GRP#29900016

3.2. COMPLETION OF HCFA-1500 (12/90)

Claims will be returned or rejected if required information is incorrect or omitted. The following required fields must be completed.

FIELD NUMBER	FIELD NAME AND DESCRIPTION
2	**Patient's Name** Enter the recipient's last name, first name, and middle initial exactly as it appears on the Medical Assistance Identification (MAID) card.
9a	**Other Insured's Policy Group Number** Enter the recipient's ten (10) digit MAID number exactly as it appears on the current MAID card.
10	**Patient's Condition** Required if recipient's condition is related to employment, auto accident, or other accident. Check the appropriate block if recipient's condition relates to any of the above.
11	**Insured's Policy Group or FECA Number** Enter the insurance policy number, if applicable.
11c	**Insurance Plan Name or Program Name** Enter the name of the insurance company, if the other insurance made a payment. If the other insurance did not make payment, leave blank.
21	**Diagnosis or Nature of Illness or Injury** Enter the appropriate ICD9 diagnosis code.
23	**Prior Authorization Number** Enter the ten (10) digit prior authorization number.
24A	**Date of Service** Enter the date in month, day, year format (MMDDYY). **DO NOT SPAN DATE.** (Enter the last date of the billing period in **"**From Date of Service"; the total units for that entire billing period should be entered in 24G. For example, if billing for services for the month of June, enter 06/30/98 in 24A. Enter the total units of services for that procedure code provided during the month of June in 24G. See claim example.)

24B **Place of Service**

The Place of Service Code is 99-other.

24D **Procedure Code**

Enter the appropriate HIPAA compliant five (5) digit procedure code and appropriate two (2) digit modifier **if applicable**.(See modifier list, Section 3-4)

24E **Diagnosis Code Indicator**

Enter 1, 2, 3, or 4, when referencing the specific diagnosis for which the recipient is being treated as indicated in Field 21.

24F **Charges**

Enter the billed charge for the service. In order to be paid correctly, detail line charges must be the total charge for the units x the rate per unit.

24G **Days or Units**

Enter the appropriate number of days or units.

NOTE: See page 3-17 regarding appropriate billing of units

26 **Patient's Account No.**

Enter the sub-provider's nine (9) digit tax ID number. Enter the three (3) digit suffix, if applicable.

28 **Total Charge**

Enter the total of all individual charges entered in Field 24F. Total each claim separately.

29 **Amount Paid**

Enter the amount paid, if any, by a private insurance. IF NO PAYMENT, LEAVE BLANK.

30 **Balance Due**

Required if private insurance made payment on the claim. Subtract the payment entered in Field 29 from the total charge entered in Field 28 and enter the net balance due in Field 30.

31 **Signature of Physician or Supplier**

A hand-written signature is required. A designated signature such as an authorized representative is acceptable. Stamped signatures are not acceptable.

Date

Enter the date in a month, day, year numeric format (MMDDYYYY). This date must be on or after the date(s) of service billed on the claim.

33 **Physician's, Supplier's Billing Name, Address, Zip Code, and Phone Number**

Enter the provider's name, address, zip code and phone number (including area code) above PIN.

Enter your eight (8) digit Medicaid provider ID beside PIN #.

Your eight (8) digit Medicaid provider ID may be found in the top right hand corner of your prior authorization letter. See PA approval sample letter on page 5-3

Enter DPH's eight (8) digit Medicaid provider ID beside GRP #. DPH's provider ID is 29900016.

3.3. MAILING INFORMATION

Send the completed HCFA-1500 (12/90) claim form to Unisys for processing as soon as possible after the service is rendered. Retain a copy in the office file.

Mail completed claims to:

Unisys
P.O. Box 2101
Frankfort, KY 40602-2101

3.4. PROCEDURE CODES FOR IMPACT PLUS

	Date of Service Prior to 10/16/03	Effective Date of Service 10/16/03 and after	Unit Value Effective 10/16/03 and after
Individual Services	X0050	90804	1 unit = 15 minutes
Group Services	X0051	90853	1 unit = 15 minutes
Collateral Services	X0058	90887	1 unit = 15 minutes
Case Management	X0064	T2023	1 unit = 1 month
After School & Summer Programs	X0086	H2019	1 unit = 15 minutes
Children's Day Treatment	X0073	T2012	1 unit = 1 hour
Partial Hospitalization	X0072	90816	1 unit = 30 minutes
Intensive Outpatient Services	X0080	90899	1 unit = 1 hour
* Therapeutic Foster Care/Group Residential Care	X0089	S5145	1 unit = 1 day
* Crisis Stabilization	X0081	S9485	1 unit = 1 day
Therapeutic Child Support Professional/Staff	X0060	H2021	1 unit = 15 minutes
Evaluation	XH100	T1023	1 unit = 1 hour

NOTE: All Impact Plus services must be prior authorized. See PA Approval Sample in Section 5.3, page 5-27.

- **For Therapeutic Foster care/Group Residential Care (S5145) and Crisis Stabilization (S9485), sub-contractors may bill either the day of admission or the day of discharge. Sub-contractors may not bill for both days.**
  *** In addition, sub-contractor ***MUST*** bill each date of service separately (claim will deny if this does not occur).**
- **Services involving 15 minute, 30 minute or one (1) hour units shall not be rounded up.**

3.5. MODIFIER CODES

The following codes may be billed with or without a modifier depending on the service authorized/provided.

Code	Service	Modifier	Modifier Description
90804	Individual Therapy	U1	Psychiatrist only
90804	Individual Therapy	none	No modifier indicates Other Professional
S5145	Therapeutic Group Residential Care/Foster Care	HQ	Therapeutic Group Residential Care
S5145	Therapeutic Group Residential Care/Foster Care	none	No modifier indicates Therapeutic Foster Care
H2021	Therapeutic Child Support	HS	Parent to Parent Support Services
H2021	Therapeutic Child Support	HM	Paraprofessional
H2021	Therapeutic Child Support	HN	Professional – BA/BS/MA/MS
H2019	Therapeutic After School/Summer Program	UG	After School Program
H2019	Therapeutic After School/Summer Program	none	No modifier indicates Summer Program

3.6. HELPFUL HINTS FOR SUCCESSFUL HCFA-1500 (12/90) FILING

- Any required documentation for claims processing must be attached to **each** claim. Each claim is processed separately.
- Be sure to include the "AS OF" date and "EOB" code when copying a remittance advice as proof of timely filing or for inquiries concerning claim status.
- Please follow up on a claim that appears to be outstanding after four weeks from your submission date.
- Field 24B (Place of Service) requires a two (2) digit code.
- Field 24E (Diagnosis Code Indicator) is a one (1) digit **only** field.
- If you are submitting a copy of a previously submitted claim on which some line items have paid and some denied, mark through or delete any line(s) on the claim already paid. If you mark through any lines, be sure to recompute your total charge in Field 28 to reflect the new total charge billed.

If you are using paper claim forms, enter all data legibly in the required fields and format. Please type or print information. Illegible fields may be entered incorrectly and may cause a delay in, or a denial of payment.

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4. ELECTRONIC DATA INTERCHANGE (EDI)

Healthcare organizations have traditionally conducted business by trading information on preprinted paper forms. The variety and volume of paper-based exchanges has grown. This has forced healthcare organizations to seek more efficient ways of communicating. Electronic Data Interchange (EDI) is structured business-to-business communications using electronic media rather than paper.

4.1. MEANS OF ELECTRONIC SUBMISSION

Unisys will process electronic transactions on either soft or hard media. We have increased our acceptance baud rates for PC-based asynchronous transmissions to 56K. We also accept CD or 3 1/2" diskettes.

4.1.1. SOFT MEDIA

- Asynchronous Modem transmission
- Mainframe Communications **(contact the Unisys EDI Technical Support Help Desk for constraints)**

4.1.2. HARD MEDIA

- CD
- 3 1/2 inch diskette

4.2. HOW TO GET STARTED

All Trading Partners are encouraged to utilize EDI rather than paper claims submission. To become a business-to-business EDI Trading Partner contact the Unisys Electronic Data Interchange Technical Support Help Desk at:

Unisys Corporation
P.O. Box 2016
Frankfort, KY 40602-2016

Telephone: 800-205-4696

4.3. FORMAT AND TESTING

All EDI Trading Partners must test successfully with Unisys and have DMS approved agreements to bill electronically before submitting production transactions. Contact the EDI Technical Support Help Desk for specific testing instructions and requirements.

4.4. ECS HELP

If you are already billing electronically, or have questions of a technical communications nature contact the EDI Technical Support Help Desk at **800-205-4696.**

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5. UNISYS GENERAL INFORMATION AND FORMS

5.1. CLAIMS MORE THAN TWELVE (12) MONTHS OLD

According to federal regulations, claims must be billed to Medicaid within 12 months of the date of service or within six (6) months of the Medicare or other insurance payment or rejection date, whichever is later. If you have not been paid for a claim that is beyond this time period, it can be considered for payment only under certain circumstances. Unisys, the fiscal agent for the Kentucky Department for Medicaid Services, provides the following guidelines to explain the time constraints for claims processing.

5.1.1. REGULAR MEDICAID CLAIMS

You must show proof of timely receipt by Unisys during the initial 12 months from the date of service; and if the claim rejects, you must show timely receipt by Unisys of a resubmission within 12 months of that rejection date. Examples of such proof are relevant remittance advices or "Return to Provider" forms sent to you from Unisys.

5.1.2. RETROACTIVE ELIGIBILITY (BACK-DATED)

Aged claims for recipients whose eligibility for medical assistance or a specific service is determined retroactive may be considered for payment if filed within one (1) year from the **issue date** noted on the MAID card. A copy of the recipient's MAID card covering the service dates must be attached **behind** the claim. **Claim submission must be within 12 months of the issue date**. It is helpful for you to write (in black ink) on the face of the claim form "Retroactive Eligibility Card Attached", or "Back-Dated Card Attached".

5.1.3. UNACCEPTABLE DOCUMENTATION

Copies of previously submitted claim forms, providers' in-house records of claims submitted, or letters detailing filing dates are not acceptable documentation of timely billing. Attachments must prove the claim was received "timely" by Unisys.

5.2. DIAGNOSIS CODES

Diagnosis codes are required in Field 21 of the HCFA-1500 (12/90). Enter the appropriate diagnosis code(s) from the Classifications or ICD-9-CM (Vol 1, 2, & 3). These books may be ordered from the following addresses:

ICD-9-CM Code Books
American Medical Association
P. O. Box 7046
Dover, DE 19903
800-621-8335

5.3. PROVIDER INQUIRY FORM

Provider Inquiry Forms may be used for any unique questions concerning claim status, paid or denied claims, and billing concerns. The mailing address for the Provider Inquiry form is:

Unisys Corporation
P.O. Box 2100
Provider Services
Frankfort, KY 40602-2100

Please keep the following points in mind when using this form:

- Send the two (2)-part completed form to Unisys. The yellow copy will be returned to you with a response.
- When resubmitting a corrected claim, do not attach a Provider Inquiry Form.
- A toll free number **800-807-1232** is available in lieu of using this form.
- To check claim status, call the Unisys Voice Response on **800-807-1301.**

PROVIDER INQUIRY FORM

Unisys Corporation
P.O. Box 2100
Frankfort, KY 40602-2100

Please remit both copies of the Inquiry Form to Unisys

1. Provider ID	3. Recipient Name (first, last)	
2. Provider Name and Address	4. Medical Assistance Number	
	5. Billed Amount	6. Claim Service Date
	7. RA Date	8. Transaction Control Number

9. Provider's Message

10. _____
Signature Date

Unisys Response:

_____This claim has been resubmitted for possible payment.

_____UNISYS can find no record of receipt of this claim as indicated above. Please resubmit.

_____This claim paid on _____in the amount of _____

_____This claim was denied on _____with EOB code_____

_____

_____

_____This claim denied on _____with EOB 00294 "KenPAC Recipient. Referring provider ID is missing or is not the KenPAC primary Title V/DCBS/clinic ID for the date(s) of service."

_____This claim denied on _____with EOB 00295 "KenPAC Recipient. Billing and/or referring provider ID is not the KenPAC primary Title V/DCBS/clinic for date(s) of service."

_____This claim denied on _____with EOB 00467 "Recipient has other medical coverage. Bill other insurance first or attach documentation of denial from the insurance carrier."

_____ Aged claim. Please see attached documentation concerning services submitted past the 12 month filing limit.

Other:

_____

_____

Signature Date

5.4. ADJUSTMENTS AND CLAIM CREDIT REQUEST

An adjustment is a change to be made to a “PAID” claim. The mailing address for the Adjustment Request form is:

Unisys Financial Services
P.O. Box 2108
Frankfort, KY 40602-2108

Please keep the following points in mind when filing an adjustment request.

- Attach a copy of the **corrected claim** and the **paid remittance advice** page to your adjustment form. For a Medicaid / Medicare crossover, attach an EOMB (Explanation of Medicare Benefits) with the claim.
- Do not send refunds on claims for which an adjustment has been filed.
- Be specific. Explain exactly what is to be changed on the claim.
- Claims showing paid zero dollar amounts are considered paid claims by Medicaid. If the paid amount of zero is incorrect, the claim will require an adjustment.

A Claim credit* is a change to be made to a "paid" claim where a refund check is involved. These types of transactions will go to the following address accompanied by a check made payable to the **Kentucky State Treasurer:**

IMPACT PLUS
Attn: Program Manager
100 Fair Oaks Lane 4WC
Frankfort, KY 40621

*See Page 5-7 for a claim credit example.

UNISYS

EXAMPLE

ADJUSTMENT AND CLAIM CREDIT REQUEST FORM

MAIL TO: UNISYS CORPORATION
P.O. BOX 2108
FRANKFORT, KENTUCKY 40602
800-807-1232
ATTN: PROVIDER RELATIONS

NOTE: A claim credit voids the claim TCN from the system -- a "new day" claim may be submitted, if necessary. This form will be returned to you if the required information and documentation for processing are not present. Please attach a corrected claim and remittance advice to adjust a claim.

<table>
<tr><td colspan="2">CHECK APPROPRIATE BOX:
CLAIM ADJUSTMENT ☐ CLAIM CREDIT ☒</td><td colspan="2">1. Original Transaction Control Number (TCN)
30101201414066800</td></tr>
<tr><td colspan="2">1. Recipient Name
McGinnis B.</td><td colspan="2">2. Recipient Medicaid Number
403999 9999</td></tr>
<tr><td rowspan="2">3. Provider Name and Address
We Care Provider
Main St.
Anytown, KY 40000
Tax ID# 610000001</td><td>4. Provider ID
29000000</td><td>5. From Date of Service
12-31-00</td><td>6. To Date of Service
12-31-00</td></tr>
<tr><td>7. Original Billed Amount
$230.50</td><td>8. Original Paid Amount
$230.30</td><td>10. Remittance Advice Date
1/12/01</td></tr>
</table>

11. Please specify **WHAT** is to be adjusted on the claim. You must explain in detail in order for an adjustment specialist to understand what needs to be accomplished by adjusting the claim.

ORIGINAL CLAIM PAID RATE AS $13.55 PER UNIT. SHOULD PAY AS $17.00 PER UNIT.

12. Please specify the **REASON** for the adjustment or claim credit request. ***INCLUDE PRIOR AUTHORIZATION NUMBER HERE:***

PLEASE CREDIT ORIGINAL CLAIM TO ALLOW UNITS TO BE RESET ON PRIOR AUTHORIZATION 1234567899.

13. Signature **Sue Clerk** 14. Date **1/13/01**

UNISYS

ADJUSTMENT AND CLAIM CREDIT REQUEST FORM

MAIL TO: UNISYS CORPORATION
P.O. BOX 2108
FRANKFORT, KENTUCKY 40602
800-807-1232
ATTN: PROVIDER RELATIONS

NOTE: A claim credit voids the claim TCN from the system -- a "new day" claim may be submitted, if necessary. This form will be returned to you if the required information and documentation for processing are not present. Please attach a corrected claim and remittance advice to adjust a claim.

<table>
<tr><td colspan="2">CHECK APPROPRIATE BOX:
CLAIM ADJUSTMENT ☐ CLAIM CREDIT ☐</td><td colspan="2">2. Original Transaction Control Number (TCN)</td></tr>
<tr><td colspan="2">9. Recipient Name</td><td colspan="2">10. Recipient Medicaid Number</td></tr>
<tr><td rowspan="2">11. Provider Name and Address</td><td>12. Provider ID</td><td>13. From Date of Service</td><td>14. To Date of Service</td></tr>
<tr><td>15. Original Billed Amount</td><td>16. Original Paid Amount</td><td>10. Remittance Advice Date</td></tr>
</table>

11. Please specify **WHAT** is to be adjusted on the claim. You must explain in detail in order for an adjustment specialist to understand what needs to be accomplished by adjusting the claim.

_____

_____

12. Please specify the **REASON** for the adjustment or claim credit request. ***INCLUDE PRIOR AUTHORIZATION NUMBER HERE:***

_____

_____

_____

13. Signature _____ 14. Date _____

5.5. RETURN TO PROVIDER LETTER

Claims and attached documentation received by Unisys will be screened for required information (listed below). If the required information is not complete, the claim will be returned to the provider with a "Return to Provider Letter" attached explaining why the claim is being returned.

A claim will be returned before processing if the following information is missing:

- Provider ID
- Original provider or authorized representative signature
- Recipient MAID number
- Recipient first and last names
- EOMB for Medicare / Medicaid crossover claims

Other reasons for return may include:

- Illegible claim date of service or other pertinent data.
- Claim lines completed exceed the limit.
- Unable to image.

UNISYS

RETURN TO PROVIDER LETTER

Date: ___ - ___ - ___

Dear Provider,
The attached claim(s) is being returned for the following reason(s). These items require correction before the claim(s) can be processed.

---

01) ___ PROVIDER ID - A valid 8 digit provider ID must be on the claim form in the appropriate field.
___ Missing ___ Not a valid provider ID

---

02) ___ PROVIDER SIGNATURE - All claims require a hand written signature in the provider signature block. No stamps.
___ Missing
___ Typed signature not valid
___ Stamped signature not valid

---

03) ___ Detail lines exceed the limit for claim type.

---

04) ___ UNABLE TO IMAGE OR KEY - Claim form/EOMB must be legible. Highlighted forms cannot be accepted. Please resubmit on a new form.
___ Print too light ___ Print too dark ___ Highlighted data fields ___ Not Legible ___ Dark copy

---

05) ___ Medicaid does not make payment when Medicare has paid the allowed amount in full.

---

06) ___ MAID number is missing.

---

07) ___ Medicare EOMB does not match the claim
___ Recipient number
___ Charges
___ Dates of service

---

08 ___ Other Reason

Please make the necessary corrections and resubmit for processing. If you have any question, please feel free to contact our Provider Relations Group, open Monday through Friday, 8:00 a.m. until 6:00 p.m. eastern standard time, at 1-800-807-1232.

Would you be interested in taking advantage of billing Medicaid electronically? If so, please contact Unisys at 1-800 -205-4696.

Initials of Clerk _____

Provider Name _____

Provider ID _____

5.6. REFERENCE LIST UNISYS CORPORATION

Addresses:

Adjustments & Claim Credits
P.O. Box 2108
Frankfort, KY 40602-2108

Cash Refund
P.O. Box 2108
Frankfort, KY 40602-2108

Claims Submission
P.O. Box 2101
Frankfort, KY 40602-2101

Electronic Claims Submission
P.O. Box 2016
Frankfort, KY 40602-2016

Provider Relations (Inquiries)
P.O. Box 2100
Frankfort, KY 40602-2100

Unisys Corporation Telephone Numbers:

Electronic Claims	800-205-4696
Provider Relations	800-807-1232
Frankfort Line	502-226-1140
Provider Enrollment	877-838-5085

Automated Voice Response System:

Claims Status Inquiries	800-807-1301

Healthcare Review **800-292-2392**

Department for Medicaid Services Addresses:

Department for Medicaid Services
275 East Main Street
Frankfort, KY 40621-0001

Department for Medicaid Services
In Kentucky and Out of Kentucky

Eligibility (Recipient)	502-564-5020
Fraud Hotline	800-372-2970
Policy	502-564-5198

Where to Order:

ICD-9-CM Code Books
American Medical Association
P. O. Box 7046
Dover, DE 19903
800-621-8335

HCFA-1500 (12/90) Claim Forms
U. S. Government Printing Office
Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 15250-7954
202-512-1800

5.7. KENTUCKY MEDICAID PROVIDER REPRESENTATIVES

5.7.1. PHONE NUMBERS AND ASSIGNED COUNTIES

VICKY HICKS 502-226-1844	DOUG DRAPER 502-226-1875	BRENDA ORBERSON 502-696-1830		STAYCE TOWLES 502-696-1831	
ASSIGNED COUNTIES	ASSIGNED COUNTIES	ASSIGNED COUNTIES		ASSIGNED COUNTIES	
Boone	Boyd	Adair	Powell	Allen	Livingston
Breckinridge	Bracken	Anderson	Pulaski	Ballard	Logan
Campbell	Bullitt	Bath	Rockcastle	Barren	Lyon
Carroll	Butler	Bourbon	Russell	Bell	Marshall
Daviess	Carter	Boyle	Scott	Breathitt	Magoffin
Gallatin	Edmonson	Casey	Taylor	Caldwell	Martin
Hancock	Elliott	Clark	Washington	Calloway	McCracken
Jefferson	Fleming	Estill	Wolfe	Carlisle	McCreary
Kenton	Franklin	Fayette	Woodford	Christian	Metcalfe
McLean	Grant	Garrard		Crittenden	Monroe
Meade	Grayson	Green		Clay	Perry
Oldham	Greenup	Hart		Clinton	Pike
Trimble	Hardin	Jackson		Cumberland	Todd
	Harrison	Jessamine		Floyd	Trigg
	Henry	Larue		Fulton	Union
	Lewis	Laurel		Graves	Warren
	Mason	Lee		Harlan	Wayne
	Muhlenberg	Lincoln		Johnson	Webster
	Nicholas	Madison		Knott	Whitley
	Ohio	Marion		Knox	Simpson
	Owen	Menifee		Henderson	
	Pendleton	Mercer		Hickman	
	Robertson	Montgomery		Hopkins	
	Rowan	Morgan		Lawrence	
	Shelby	Nelson		Leslie	
	Spencer	Owsley		Letcher	

PROVIDER RELATIONS 1-800-807-1232

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6. ATTACHMENT

6.1. REMITTANCE ADVICE

KENTUCKY MEDICAID REMITTANCE ADVICE FOR IMPACT PLUS REIMBURSEMENT

This packet is intended as a step-by-step guide in reading your Unisys Remittance Advice. The sections following are organized to describe all major categories related to processing/adjudicating claims. To enhance this document's usability, detailed descriptions of the fields on each page are discussed, reading the data from left to right, top to bottom.

All Remittance Advice will have a **"banner page"** as the first page. **The "banner page" will contain provider specific information regarding upcoming meetings and workshops, "top ten" billing errors, policy updates, billing changes etc. It is imperative that you pay close attention to this page.**

KENTUCKY DEPARTMENT FOR MEDICAID SERVICES PAGE: 1
AS OF 08/09/2002 MEDICAID MANAGEMENT INFORMATION SYSTEM RUN DATE: 08/10/2002
REMITTANCE ADVICE
---- NEWSLETTER UPDATE ----

**********ATTENTION PROVIDER**********
THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, CMS,SHARP AND HAWK HAVE DEVELOPED A SERIES OF FREE WORKSHOPS, PRODUCTS AND SERVICES TO PROVIDE PRACTICAL INFORMATION ON HOW HIPAA WILL AFFECT MEDICAL PRACTICES. FOR DATES, TIMES AND LOCATIONS OF A WORKSHOP NEAR YOU, GO TO HTTP://WWW.KYMA.ORG/HIPAA_CMS_FLYER.PDF HAVE HIPAA QUESTIONS? SEND YOUR EMAILS TO HAWK@LISTSERV.LOUISVILLE.EDU. INDIVIDUALS CAN SUBSCRIBE TO A LIST OR CHANGE THEIR NAME IF ALREADY SUBSCRIBED BY SENDING AND EMAIL FROM YOUR EXISTING ADDRESS TO LISTSERV@LISTSERV.LOUISVILLE.EDU AND ENTERING THE FOLLOWING IN BODY OF EMAIL(DO NOT ENTER SUBJECT) SUBSCRIBE HAWK YOURFIRSTNAME YOURLASTNAME IF YOU HAVE FURTHER QUESTIONS, GO TO HTTP://WWW.ARCHIMEDES-COMMUNITY.ORG/SIGS/LISTSERVS/LISTSERVS.HTM.

6.2. EXAMPLES OF PAGES IN REMITTANCE ADVICE

There are several types of pages contained in a Remittance Advice, however if a provider does not have activity during the cycle in that particular category, those pages will not be included. Following are examples of pages which may appear in your Remittance Advice:

Paid Claims	This section will list all claims paid in the cycle.
Denied Claims	This section will list all claims that denied in the cycle.
Returned Claims	This section will list all claims that have been returned to the provider (RTP) via an RTP letter. The RTP letter will explain why the claim is being returned. These claims are returned because they are missing information pertinent to processing.
Claims In Process	This section will list all claims that have been suspended in current and previous cycles. The provider should maintain this page and compare with future Remittance Advices until all the claims listed have appeared on the PAID CLAIMS page or the DENIED CLAIMS page. Until that time, the provider should not resubmit the claims listed in this section.
Adjusted Claims	This section will list all claims that have been submitted and processed for adjustment or claim credit transactions.
Mass Adjusted Claims	This section will list all claims that have been mass adjusted at the request of the Department for Medicaid Services (DMS).
Accounts Receivable Summary	This section will list financial transactions with activity during the week of the payment cycle. **NOTE: It is imperative the provider maintains any accounts receivables page with an outstanding balance.**
Summary of Benefits Page	This section will detail all categories contained in the Remittance Advice for the current cycle, month to date, and year to date. Explanation of Benefit (EOB) codes listed throughout the Remittance Advice will be defined in this section.

The header information that follows is contained on every page of the Remittance Advice.

Kentucky Department for Medicaid Services Medicaid Management Information System Remittance Advice	Title
Page:	The number of the page within each Remittance Advice.
AS OF:	The date the payment cycle was adjudicated.
RUN DATE:	The date the Remittance Advice was printed.
RA NUMBER:	A system generated number for the Remittance Advice
PROVIDER NAME:	The name of the provider that billed. (The type of provider is listed directly below the name of provider.)
CLAIM TYPE:	The type of claims listed on the Remittance Advice.
PROVIDER ID:	The eight-digit Medicaid assigned provider ID of the billing provider.

The categories of a remittance advice are listed in the following order:

- Returned
- Paid
- Denied
- Claims In Process
- Adjusted
- Accounts Receivable Summary
- Summary of Benefits

Claims are listed alphabetically by recipient last name for each category. In addition, straight Medicaid claims are listed first for each category followed by crossover claims.

6.3. TRANSACTION CONTROL NUMBER (TCN)

A transaction control number (TCN) is assigned by Unisys to each claim. During the imaging process a unique control number is assigned to each individual claim for identification, efficient retrieval, and tracking. The TCN consists of 17 digits and contains the following information.

0 - 02275 - 0 - 0 - 200 - 0 - 001 - 01

1 2 3 4 5 6 7 8

1. Claim Input Indicator
   - 0 = Exam-entered
   - 1 = Keyed
   - 2 = Accounts Receivable
   - 3 = Electronic Claims Submission (ECS)
   - 4 = State converted Turn-Around-Documents (TADS) through 11/30/95. Beginning 12/1/95, any claim that generates a credit and sufficient money isn't available to satisfy the amount due, the claim credit TCN will reflect a (4) for financial reporting.
   - 5 = No Pay
   - 6 = Electronic Point of Service (POS)
   - 7 = Optional Character Recognition (OCR)
   - 8 = Adjustments/Credits-State Converted History Only
   - 9 = Mass Adjustments - State Converted History and New Day Mass Adjusted/Credit Claims
2. Date of Receipt (Calendar Year and Julian Date; 2002, 275=October 2)
3. Not used unless state converted history then will contain previous contractor regions (10, 20, 40, 50, 60, 70, 80, or 98).
4. Not used unless state converted history then the 2nd digit of previous contractor region will be displayed.
5. Batch Number (Batch Range) examples:
   - 000-210 = HCFA-1500
   - 211-259 = HCFA-1500 Practitioner (with attachments)
   - 560-579 = Return to Provider
   - 700-749 = HCFA-1500 Crossover
   - 760-769 = Credits
   - 770-779 = Adjustments (Proof)
   - 900-901 = HCFA-1500, Special Batch
   - 910-911 = HCFA-1500 Crossover, Special Batch
6. Type of Document:
   - 0 = New Day Claim
   - 1 = Credit
   - 2 = Adjustment
   - 3 = Void
   - 4 = State Converted History
   - 5 = State Converted Suspense
7. Document Number Within the Batch.
8. Line Number Within the Claim.

KENTUCKY DEPARTMENT FOR MEDICAID SERVICES — PAGE: 2
AS OF 01/12/2001 — MEDICAID MANAGEMENT INFORMATION SYSTEM — RUN DATE: 01/12/2001
REMITTANCE ADVICE

RA NUMBER: 999999
PROVIDER NAME: DMH/DCBS ASSOCIATE NAME
IMPACT PLUS
CLAIM TYPE: PROFESSIONAL SERVICES
PROVIDER ID: 29100000/29200000

* P A I D C L A I M S *

INVOICE NUMBER	RECIPIENT NAME	RECIPIENT IDENTIFICATION NUMBER	TCN	CLAIM SERVICE DATES FROM	CLAIM SERVICE DATES THRU	BILLED CHARGES	AMT. FROM OTHER SOURCES	CLAIM PMT AMOUNT	EOB
610000001	J	3120039999	30101201405095600	12/31/2003	12/31/2003	230.50	0.00	230.30	00379
01 PS: 99 PROC: XXXXX MOD: 01001 QTY: 1				12/31/2003	12/31/2003	230.50	0.00	230.30	00365
610000001	J	4069999999	30101201410032200	12/31/2003	12/31/2003	230.50	0.00	230.30	00379
01 PS: 99 PROC: XXXXX MOD: 01001 QTY: 1				12/31/2003	12/31/2003	230.50	0.00	230.30	00365
610000001	M	4049999999	30101201409059200	12/31/2003	12/31/2003	230.50	0.00	230.30	00379
01 PS: 99 PROC: XXXXX MOD: 02001 QTY: 1				12/31/2003	12/31/2003	230.50	0.00	230.30	00365
610000001 MCGINNIS	B	4039999999	30101201414066800	12/31/2003	12/31/2003	230.50	0.00	230.30	00379
01 PS: 99 PROC: XXXXX MOD: 03002 QTY: 1				12/31/2003	12/31/2003	230.50	0.00	230.30	00365
610000001 OTIS	J	4049999999	30101201415076500	12/31/2003	12/31/2003	230.50	0.00	230.30	00379
01 PS: 99 PROC: XXXXX MOD: 02001 QTY: 1				12/31/2003	12/31/2003	230.50	0.00	230.30	00365
610000001 PALMER	C	4020039999	30101201407089100	12/31/2003	12/31/2003	230.50	0.00	230.30	00379

6.4. PAID CLAIMS PAGE

INVOICE NUMBER	The tax identification number of the individual provider who performed the service.
RECIPIENT NAME	The recipient's last name and first initial.
IDENTIFICATION NUMBER	The recipient's 10-digit Medical Assistance Identification number (MAID) as it appears on the recipient's Medicaid card.
TCN	The 17-digit unique system generated identification number assigned to each claim by Unisys.
CLAIM SERVICE DATES FROM THRU	The date(s) the service was provided in month, day, and year numeric format.
BILLED CHARGES	The provider's charge for services provided.
AMT FROM OTHER SOURCES	Amount paid, if any, by private insurance **(excluding MEDICAID and Medicare).**
CLAIM PMT AMOUNT	The total dollar amount reimbursed by Medicaid for the claim listed.
EOB	Explanation of Benefit. All EOB's detailed on the Remittance Advice are listed with a description/definition on the SUMMARY OF BENEFITS PAGE of the Remittance Advice.
01,02, ETC	The detail number billed on the claim.
PS	The place of service code billed per detail.
PROC	The procedure code billed per detail.
MOD	The modifier billed per detail.
QTY	The number of times the service was performed per detail.
DOS	The date of service billed per detail.
BILLED CHARGES	The provider's charge per detail.
AMT FROM OTHER SERVICES	The amount paid per detail from a private insurance company.
CLAIM PMT AMT	The amount paid per detail.
CLAIMS PAID ON THIS RA	The total number of paid claims on the Remittance Advice.
TOTAL BILLED	The total dollar amount billed by the provider for all claims listed on the PAID CLAIMS page of the Remittance Advice.
TOTAL PAID	The total dollar amount paid by Medicaid for all claims listed on the PAID CLAIMS page of the Remittance Advice.

NOTE: If the claim type is for crossover services, the Medicare paid date, approved amount, and paid amount is listed in the detail area.

KENTUCKY DEPARTMENT FOR MEDICAID SERVICES — PAGE: 4
AS OF 01/12/2001 — MEDICAID MANAGEMENT INFORMATION SYSTEM — RUN DATE: 01/12/2001
REMITTANCE ADVICE

RA NUMBER: 999999
PROVIDER NAME: DMH/DCBS ASSOCIATE NAME
IMPACT PLUS
CLAIM TYPE: PROFESSIONAL SERVICES
PROVIDER ID: 29100000/29200000

* D E N I E D C L A I M S *

INVOICE NUMBER	RECIPIENT NAME	RECIPIENT IDENTIFICATION NUMBER	TCN	CLAIM SERVICE DATES FROM	CLAIM SERVICE DATES THRU	BILLED CHARGES	AMT. FROM OTHER SOURCES	CLAIM PMT AMOUNT	EOB
610000001	J	3120039999	30101201411073300	12/31/2003	12/31/2003	230.50	0.00	0.00	00000
01 PS: 99 PROC: XXXXX MOD: 01001 QTY: 1				12/31/2003	12/31/2003	230.50	0.00	0.00	00482
REMARK CODES: 01 00490									
RELATED HISTORY - LINE 01 HISTORY TCN 30100501405095600 DATE PAID									
610000001	J	4069999999	30101201416070000	12/31/2003	12/31/2003	230.50	0.00	0.00	00000
01 PS: 99 PROC: XXXXX MOD: 01001 QTY: 1				12/31/2003	12/31/2003	230.50	0.00	0.00	00482
REMARK CODES: 01 00490									
RELATED HISTORY - LINE 01 HISTORY TCN 30100501410032200 DATE PAID									
610000001	M	4049999999	30101201415085000	12/31/2003	12/31/2003	230.50	0.00	0.00	00000
01 PS: 99 PROC: XXXXX MOD: 01001 QTY: 1				12/31/2003	12/31/2003	230.50	0.00	0.00	00482
REMARK CODES: 01 00490									
RELATED HISTORY - LINE 01 HISTORY TCN 30100501409059200 DATE PAID									
610000001	ALEXANDER R	4079999999	30101201405010300	12/31/2003	12/31/2003	912.11	0.00	0.00	00000
01 PS: 99 PROC: XXXXX MOD: 06013 QTY: 1				12/31/2003	12/31/2003	912.11	0.00	0.00	00151
REMARK CODES: 01 00151									

CLAIMS DENIED ON THIS RA: 1,373.11 TOTAL BILLED: 1.373.11 TOTAL PAID: 0.00

6.5. DENIED CLAIMS PAGE

INVOICE NUMBER	The tax identification number of the individual provider who performed the service.
RECIPIENT NAME	The recipient's last name and first initial.
IDENTIFICATION NUMBER	The recipient's 10-digit Medical Assistance Identification (MAID) number **(as it appears on the recipient's Medicaid card.)**
TCN	The 17-digit unique system generated identification number assigned to each claim by Unisys.
CLAIM SERVICE DATES FROM THRU	The date(s) the service was provided in month, day, and year numeric format.
BILLED CHARGES	The provider's charge for services provided.
AMT. FROM OTHER SOURCES	Amount paid, if any, by private insurance **(excluding Medicaid and Medicare).**
CLAIM PAID AMOUNT	The total dollar amount reimbursed by Medicaid for the claim listed.
EOB	Explanation of Benefit. All EOB's detailed on the Remittance Advice are listed with a description/definition on the SUMMARY OF BENEFITS PAGE of the Remittance Advice.
01,02, ETC	The detail number billed on the claim.
PS	The place of service code billed per detail.
PROC	The procedure code billed per detail.
QTY	The number of times the service was performed per detail.
DOS	The date of service billed per detail.
BILLED CHARGE	The provider's charge per detail.
AMT FROM OTHER SOURCES	The amount paid per detail from a private insurance company.
CLAIM PMT AMT	The amount paid per detail.
REMARK CODES	Any error status code the claim may deny for will be listed with the detail affected.
	NOTE: When the claim type indicates "professional crossovers", the Medicare paid date, approved amount, and paid amount will appear under the detail information.
CLAIMS DENIED ON THIS RA	The total number of denied claims on the Remittance Advice.
TOTAL BILLED	The total dollar amount billed by the provider for all claims listed on the DENIED CLAIMS page of the Remittance Advice.
TOTAL PAID	There will not be a total paid amount on the denied pages of the remittance advice.

```
                                    KENTUCKY DEPARTMENT FOR MEDICAID SERVICES                                    PAGE:   9
AS OF 01/12/2001                     MEDICAID MANAGEMENT INFORMATION SYSTEM                        RUN DATE: 01/12/2001
                                              REMITTANCE ADVICE

RA NUMBER: 999999                                                    PROVIDER NAME:   DMH/DCBS ASSOCIATE NAME
                                                                     IMPACT PLUS
CLAIM TYPE: PROFESSIONAL SERVICES                                    PROVIDER ID: 29100000/29200000

                                  *   A D J U S T E D   C L A I M S   *
                                                                                                    AMT. FROM
    INVOICE    RECIPIENT IDENTIFICATION                  CLAIM SERVICE DATES    BILLED              OTHER     CLAIM PMT
    NUMBER          NAME      NUMBER          TCN          FROM      THRU      CHARGES             SOURCES     AMOUNT    EOB
  1  *** CREDIT TO CLAIM 0100501405095600 ORIGINALLY PAID ON 01/05/2001
        FOR RECIPIENT                   J       RECIP MAID # 3120039999
        PROVIDED 12/31/2003     BILLED AMOUNT:       230.50    PAID AMOUNT:        230.30
        ADJ RSN CODE: 60
     *** NEW CLAIM 01012200770202300
610000001             J       3120039999 01012201770202300 12/31/2003-12/31/2003      230.50                0.00   230.30 00311
  01   PS: 22   PROC: XXXXX   MOD: 01001     QTY:     17    12/31/2003-12/31/2003      230.50                0.00   230.30-00311
THE NET EFFECT OF THIS ADJUSTMENT IS         230.30-
THE TOTAL NET EFFECT ON THIS RA IS           230.30-
  CLAIMS ADJUST/CREDIT ON THIS RA:       2                   TOTAL BILLED:         0.00             TOTAL PAID:       0.00
```

Providers have an option of requesting an adjustment, as indicated above; or requesting a cash refund (form and instructions for completion can be found in the Impact Plus Billing Instructions).
*If a cash refund is submitted, an adjustment **CANNOT** be filed.*
*If an adjustment is submitted, a cash refund **CANNOT** be filed.*

6.6. ADJUSTED CLAIMS PAGE

The information on this page will read left to right and will not follow the general headings until ***** NEW CLAIM** information begins.

INVOICE NUMBER	The tax identification number of the individual provider who performed the service.
RECIPIENT NAME	The recipient's last name and first initial.
IDENTIFICATION NUMBER	The recipient's 10-digit Medical Assistance Identification number as it appears on the recipient's MAID card.
TCN	The 17-digit unique system generated identification number assigned to each claim by Unisys.
CLAIM SERVICE DATES FROM THRU	The date or dates the service was provided in month, day, and year numeric format.
BILLED CHARGES	The usual and customary charge for services provided for the recipient.
AMOUNT FROM OTHER SOURCES	Amount paid, if any, by private insurance **(excluding Medicaid and Medicare).**
CLAIM PMT AMOUNT	The total dollar amount reimbursed by Medicaid for the claim listed.
EOB	Explanation of Benefit. All EOB's detailed on the Remittance Advice are listed with a description/definition on the SUMMARY OF BENEFITS PAGE of the Remittance Advice.
1 * ADJUSTMENT TO CLAIM**	This begins the information for the original claim data to be adjusted/credited. The number to the left of the asterisks indicates the item number of the adjustment transaction being detailed. In this example it is "1", indicating the first adjustment/credit transaction listed. The TCN of the original claim being adjusted/credited follows.
ORIGINALLY PAID ON	The date the original claim being adjusted/credited was paid by Medicaid.
FOR RECIPIENT	The recipient's last and first name.
RECIPIENT MAID NUMBER	The MAID number for the recipient.
PROVIDED	The date the service was provided in month, day, and year numeric format.
BILLED AMOUNT	The amount that was billed on the original claim being adjusted/credited.
PAID AMOUNT	The original amount paid by Medicaid.
ADJ RSN CODE	Denotes the reason for the adjustment/credit. All reason codes detailed on the Remittance Advice are listed with a description/definition on the SUMMARY OF BENEFITS PAGE of the Remittance Advice.

***** NEW CLAIM**	This begins the new information of the adjusted claim and is followed by a seventeen (17) digit TCN assigned to the adjustment/credit that is listed. The new TCN will notify the provider if the transaction is a credit or an adjustment. The sixth digit from the right will indicate a claim credit if it is a "1" and an adjustment if it is a "2".
	At this point, the information follows the general headings of the Remittance Advice indicating the adjusted transaction results.
INVOICE NUMBER	The tax identification number of the individual provider who performed the service.
RECIPIENT NAME	The recipient's last name and first initial.
IDENTIFICATION NUMBER	The recipient's 10-digit Medical Assistance Identification number as it appears on the recipient's MAID card.
TCN	The 17-digit unique system generated identification number assigned to each claim by Unisys.
CLAIM SERVICE DATES FROM THRU	The date or dates the service was provided in month, day, and year numeric format.
BILLED CHARGES	The usual and customary charge for services provided for the recipient.
AMOUNT FROM OTHER SOURCES	Amount paid, if any, by private insurance **(excluding Medicaid and Medicare).**
CLAIM PMT AMOUNT	The total dollar amount reimbursed by MEDICAID for the claim listed.
EOB	Explanation of Benefit. All EOB's detailed on the Remittance Advice are listed with a description/definition on the SUMMARY OF BENEFITS PAGE of the Remittance Advice.
THE NET EFFECT OF THIS ADJUSTMENT IS	This is the sum of the specific transaction detailed for this adjustment and its effect on the total transaction.
THE TOTAL NET EFFECT OF THIS RA IS	This is the sum of all transactions detailed for adjustments/credits on the Remittance Advice and the total effect on the transactions.
CLAIMS ADJUST/CREDIT ON THIS RA	The number of transactions (adjustments and/or claim credits) on the Remittance Advice.
TOTAL BILLED	The total dollar amount billed on the ADJUSTED CLAIMS page of the Remittance Advice.
TOTAL PAID	The total dollar amount paid on the ADJUSTED CLAIMS page of the Remittance Advice.

KENTUCKY DEPARTMENT FOR MEDICAID SERVICES — PAGE: 10
AS OF 01/12/2001 — MEDICAID MANAGEMENT INFORMATION SYSTEM — RUN DATE: 01/12/2001
REMITTANCE ADVICE

RA NUMBER: 999999

PROVIDER NAME: DMH/DCBS ASSOCIATE NAME
IMPACT PLUS
PROVIDER ID: 29100000/29200000

* S U M M A R Y O F B E N E F I T S P A G E *

CHECK NUMBER 9999999

CLAIMS REMITTANCE SUMMARY	NUMBER PROCESSED	BILLED AMOUNT	NET PAY AMOUNT
PAID CLAIMS	12	2763.60	2763.60
PAID ADJ. CLAIMS	1	230.50	230.30-
PAID MASS ADJ. CLAIMS	0	0.00	0.00
DENIED CLAIMS	8	4570.44	0.00
CLAIMS IN PROCESS	0	0.00	0.00
RETURNED CLAIMS	0		
BEGINNING CLAIM CREDIT BALANCE			0.00
ENDING CLAIM CREDIT BALANCE			0.00
A/R TRANSACTIONS DEBIT			0.00
A/R TRANSACTIONS CREDIT			0.00
TOTAL PROVIDER CREDIT BALANCE			0.00
SUBTOTAL CHECK AMOUNT			2533.30
BEGINNING POS/ELIG CREDIT BALANCE			0.00
MINUS POINT OF SALE FEES			0.00
MINUS ELIGIBILITY TRANSACTIONS			0.00
ENDING POS/ELIG CREDIT BALANCE			0.00
NET CHECK AMOUNT			2533.30
MONTH-TO-DATE PAID CLAIMS	12	2763.60	2763.60
MONTH-TO-DATE PAID ADJ/FINANCIAL	1	230.50	230.30-
MONTH-TO-DATE DENIED CLAIMS	8	4570.44	
YEAR-TO-DATE PAID CLAIMS	12	2763.60	2763.60
YEAR-TO-DATE PAID ADJ/FINANCIAL	1	230.50	230.30-
YEAR-TO-DATE DENIED CLAIMS	8	4570.44	
NET 1099 AMOUNT			2763.60

KENTUCKY DEPARTMENT FOR MEDICAID SERVICES — PAGE: 12
AS OF 08/14/1998 — MEDICAID MANAGEMENT INFORMATION SYSTEM — RUN DATE: 08/14/1998
REMITTANCE ADVICE

RA NUMBER: 999999
PROVIDER NAME: DMH/DCBS ASSOCIATE NAME
IMPACT PLUS
CLAIM TYPE: PROFESSIONAL SERVICES
PROVIDER ID: 29100000/29200000

EOB	THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION OF BENEFIT (EOB) CODES THAT APPEAR ABOVE:	COUNT
00110	CLAIM SUSPENDED FOR REVIEW.	32
00121	THIS SERVICE IS NOT PAYABLE FOR A QMB-ONLY RECIPIENT	67
	.....	
	.....	
00151	CLAIM DENIED. PROCEDURE NDC CODE INVALID FOR DATES OF SERVICE	1,320
00251	INCORRECT RECIPIENT IDENTIFICATION NUMBER.	4
00260	CLAIM DENIED. THE KENTUCKY MEDICAL ASSISTANCE PROGRAM IS ONLY RESPONSIBLE FOR BUY-IN PREMIUMS FOR THIS RECIPIENT. MEDICAID CLAIMS ARE NOT REIMBURSIBLE FOR THIS RECIPIENT.	13
00365	FEE ADJUSTED TO MAXIMUM ALLOWABLE.	11,642
00379	PAID BY MEDICAID	11,642
00482	CLAIM/DETAIL DENIED. DUPLICATE SERVICE BILLED.	381

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                                KENTUCKY DEPARTMENT FOR MEDICAID SERVICES                              PAGE:  13
AS OF 08/14/1998                 MEDICAID MANAGEMENT INFORMATION SYSTEM                  RUN DATE: 08/14/1998
                                          REMITTANCE ADVICE

RA NUMBER: 999999                                                  PROVIDER NAME:   DMH/DCBS ASSOCIATE NAME
                                                                   IMPACT PLUS
CLAIM TYPE: PROFESSIONAL SERVICES                                  PROVIDER ID: 29100000/29200000

REMARK  THE FOLLOWING IS A DESCRIPTION OF THE REMARK CODES THAT APPEAR ABOVE:                    COUNT

  00121  THIS SERVICE NOT PAYABLE FOR QMB-ONLY RECIPIENTS.                                        67
  00151  PROCEDURE/NDC INVALID FOR FDOS.                                                       1,320
  00249  RECIPIENT NOT ON ELIGIBILITY FILE - RECYCLE FOR E250.                                    4
  00251  RECIPIENT CHECK DIGIT INVALID.                                                           4
  00259  RECIPIENT NOT ELIGIBLE ON HEADER OR DETAIL DOS - RECYCLE FOR E00254 AND                  2
       E00262.
  00260  CLAIM NOT PAYABLE FOR BENE AID CATEGORY.                                                13
  00490  EXACT DUPLICATE CLAIM - DETAIL.                                                        381
* END OF RA *
```

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                                KENTUCKY DEPARTMENT FOR MEDICAID SERVICES                          PAGE:  14
AS OF 08/14/1998                 MEDICAID MANAGEMENT INFORMATION SYSTEM                  RUN DATE: 08/14/1998
                                          REMITTANCE ADVICE

RA NUMBER: 999999                                                 PROVIDER NAME:   DMH/DCBS ASSOCIATE NAME
                                                                  IMPACT PLUS
CLAIM TYPE: PROFESSIONAL SERVICES                                 PROVIDER ID: 29100000/29200000

  RSN THE FOLLOWING IS A DESCRIPTION OF THE ADJUSTMENT REASONS THAT APPEAR ABOVE:                  COUNT:

  60  PROVIDER INITIATED ADJUSTMENT                                                                 1
* END OF RA *
```

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                                KENTUCKY DEPARTMENT FOR MEDICAID SERVICES                                PAGE:  15
AS OF 08/14/1998                 MEDICAID MANAGEMENT INFORMATION SYSTEM                      RUN DATE: 08/14/1998
                                        REMITTANCE ADVICE

RA NUMBER: 999999                                                 PROVIDER NAME:   DMH/DCBS ASSOCIATE NAME
                                                                  IMPACT PLUS
CLAIM TYPE: PROFESSIONAL SERVICES                                 PROVIDER ID: 29100000/29200000

 RTP CODE  RETURN CODE DESCRIPTION                                                                  COUNT

    05     CLAIM FORM/EOMB NOT LEGIBLE                                                                2
    07     RECIPIENT ID NUMBER MISSING                                                                1
* END OF RA *
```

KENTUCKY DEPARTMENT FOR MEDICAID SERVICES — PAGE: 10
AS OF 01/12/2001 — MEDICAID MANAGEMENT INFORMATION SYSTEM — RUN DATE: 01/12/2001
REMITTANCE ADVICE

RA NUMBER: 999999

PROVIDER NAME: DMH/DCBS ASSOCIATE NAME
IMPACT PLUS
PROVIDER ID: 29100000/29200000

* S U M M A R Y O F B E N E F I T S P A G E *

CHECK NUMBER 9999999

CLAIMS REMITTANCE SUMMARY	NUMBER PROCESSED	BILLED AMOUNT	NET PAY AMOUNT
PAID CLAIMS	12	2763.60	2763.60
PAID ADJ. CLAIMS	1	230.50	230.30-
PAID MASS ADJ. CLAIMS	0	0.00	0.00
DENIED CLAIMS	8	4570.44	0.00
CLAIMS IN PROCESS	0	0.00	0.00
RETURNED CLAIMS	0		
BEGINNING CLAIM CREDIT BALANCE			0.00
ENDING CLAIM CREDIT BALANCE			0.00
A/R TRANSACTIONS DEBIT			0.00
A/R TRANSACTIONS CREDIT			0.00
TOTAL PROVIDER CREDIT BALANCE			0.00
SUBTOTAL CHECK AMOUNT			2533.30
BEGINNING POS/ELIG CREDIT BALANCE			0.00
MINUS POINT OF SALE FEES			0.00
MINUS ELIGIBILITY TRANSACTIONS			0.00
ENDING POS/ELIG CREDIT BALANCE			0.00
NET CHECK AMOUNT			2533.30
MONTH-TO-DATE PAID CLAIMS	12	2763.60	2763.60
MONTH-TO-DATE PAID ADJ/FINANCIAL	1	230.50	230.30-
MONTH-TO-DATE DENIED CLAIMS	8	4570.44	
YEAR-TO-DATE PAID CLAIMS	12	2763.60	2763.60
YEAR-TO-DATE PAID ADJ/FINANCIAL	1	230.50	230.30-
YEAR-TO-DATE DENIED CLAIMS	8	4570.44	
NET 1099 AMOUNT			2763.60

6.7. SUMMARY OF BENEFITS PAGE

CLAIMS REMITTANCE SUMMARY	Page identification.
CHECK NUMBER	The number of the Warrant Check associated with the Remittance Advice.
NUMBER PROCESSED	The number of claims processed under each individual heading (listed on the left of page), where applicable.
BILLED AMOUNT	The total billed dollar amount for services billed by the provider on the Remittance Advice.
NET PAY AMOUNT	The total dollar amount reimbursed by the Department for Medicaid Services (DMS) under each individual heading (listed on the left of page), where applicable.
PAID CLAIMS	The number of paid claims processed, amount billed, and amount paid by Medicaid. These figures correspond with the summary line of the last page of PAID CLAIMS section.
PAID ADJ CLAIMS	The number of adjusted/credited claims processed, adjusted/credited amount billed, and adjusted/credited amount paid or recouped by Medicaid. If money is recouped, the dollar amount will be followed by a negative (-) sign. These figures correspond with the summary of the last page of the ADJUSTED CLAIMS section.
PAID MASS ADJ CLAIMS	The number of mass adjusted/credited claims, mass adjusted/credited amount billed, and mass adjusted/credited amount paid or recouped by Medicaid. These figures correspond with the summary line of the last page of the MASS ADJUSTED CLAIMS section. *Mass Adjustments are initiated by* Medicaid *and Unisys for issues that effect a large number of claims or providers. These adjustments will have their own section "MASS ADJUSTED CLAIMS" page, but will be formatted the same as the ADJUSTED CLAIMS page.*
DENIED CLAIMS	These figures correspond with the summary line of the last page of the DENIED CLAIMS section.
CLAIMS IN PROCESS	The number of claims processed that suspended along with the amount billed of the suspended claims. These figures correspond with the summary line of the last page of the CLAIMS IN PROCESS section.
BEGINNING CLAIM CREDIT BALANCE	The amount of money the provider owes Medicaid as a result of a claim adjustment, claim credit, or mass adjustment that could not be satisfied from the previous Remittance Advice.
ENDING CLAIM CREDIT BALANCE	The balance of money owed to Medicaid after monies received during the current Remittance Advice have been applied.

A/R TRANSACTION DEBIT	The total dollar amount paid out to a provider once a request has been received from Medicaid.
A/R TRANSACTION CREDIT	The total dollar amount recouped to satisfy outstanding claim credit balances or accounts receivable.
TOTAL PROVIDER CREDIT BALANCE	The total dollar amount the provider owes Medicaid as a result of a claim adjustments, claim credits, mass adjustments, and/or an accounts receivable balance unsatisfied pertaining to the current Remittance Advice.
SUBTOTAL CHECK AMOUNT	The total of the provider warrant check after the above figures have been calculated.
BEGINNING POS/ELIG CREDIT BALANCE	Not Applicable.
NET CHECK AMOUNT	The total of the provider check after the POS fees and eligibility transactions have been subtracted from the SUBTOTAL CHECK AMOUNT.
MONTH-TO-DATE PAID CLAIMS	A month to date number and total billed and reimbursed of paid claims.
MONTH-TO-DATE PAID ADJ/FINANCIAL	A month to date number and total billed and reimbursed of adjusted claims and financial transactions.
MONTH-TO-DATE DENIED CLAIMS	A month to date number and total billed of denied claims.
YEAR-TO-DATE PAID CLAIMS	A year to date number and total billed and reimbursed of paid claims.
YEAR-TO-DATE ADJ/FINANCIAL	A year to date number and total billed and reimbursed of adjusted claims and financial transactions.
YEAR-TO-DATE DENIED CLAIMS	A year to date number and total billed of denied claims.
NET 1099 AMOUNT	The total year to date taxable income received from Medicaid.

6.8. EXPLANATION OF BENEFITS

EOB	A 5-digit number denoting the EXPLANATION OF BENEFITS detailed on the Remittance Advice.
EOB CODE DESCRIPTION	Description of the EOB Code. All EOB Codes detailed on the Remittance Advice are listed with a description/definition.
COUNT	Total number of times an EOB Code is detailed on the Remittance Advice.
EXPLANATION OF REMARK	
REMARK	A 5-digit number denoting the error identified on the Remittance Advice.
REMARK CODE DESCRIPTION	Description of the Remark Code. All remark codes detailed on the Remittance Advice are listed with a description/definition.
COUNT	Total number of times an Remark Code is detailed on the Remittance Advice
EXPLANATION OF ADJUSTMENT CODES	
ADJUSTMENT CODE	A 2-digit number denoting the reason for the adjustment/credit.
ADJUSTMENT CODE DESCRIPTION	Description of the adjustment Code. All adjustment codes detailed on the Remittance Advice are listed with a description/definition.
COUNT	Total number of times an adjustment Code is detailed on the Remittance Advice.
EXPLANATION OF RTP CODES	
RTP CODE	A 2-digit number denoting the reason for returning the claim.
RETURN CODE DESCRIPTION	Description of the RTP Code. All RTP codes detailed on the Remittance Advice are listed with a description/definition.
COUNT	Total number of times an RTP Code is detailed on the Remittance Advice.

7. HIPAA INFORMATION FOR BILLING

The Health Insurance Portability and Accountability Act (HIPAA) Information for Billing

Standard Transaction Formats for Billing Kentucky Medicaid

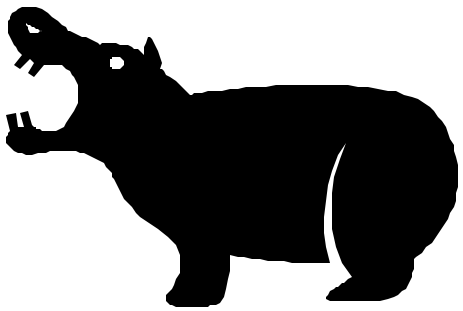
To simplify the electronic exchange of financial and administrative health care transactions, the Health Insurance Portability and Accountability Act (HIPAA) transactions standards will require all health plans, health care clearinghouses and health care providers to use or accept the following electronic transactions. Prior to the passage of HIPAA in 1996, Congress determined that to improve the efficiency and effectiveness of the health care system and decrease administrative burdens on providers (i.e., medical practices, hospitals and health care plans) it was necessary to have national standards for the electronic exchange of health care transactions. The following formats will replace the hundreds of proprietary and local formats used throughout the health insurance industry. The transaction standards take effect for Kentucky Medicaid on October 16, 2003:

Code Sets

The regulation also requires the use of standardized procedure/diagnosis coding to represent the data to be transmitted. Code Sets include:

1. Current Procedure Terminology (CPT-4)
2. International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)
3. HCFA Common Procedure Coding System (HCPCS)
4. ADA Codes on Dental Procedures and Nomenclature, 2nd Edition (CDT-2)
5. Revenue Codes

NOTE: Please be aware that no Medicaid local codes will be accepted after October 16, 2003.



HIPAA Transaction Standards

The HIPAA transactions and code set standards are rules to standardize the electronic exchange of patient-identifiable, health-related information. They are based on electronic data interchange (EDI) standards, which allow the electronic exchange of information from computer to computer without human involvement.

These standards apply to nine types of administrative and financial health care transactions used by payers, physicians and other providers, including claims submission, claims status reporting, referral certification and authorization, and coordination of benefits.

HIPAA EDI Transactions

Health Care Eligibility Inquiry and Response (270 & 271)
Health Care Claim Status Inquiry / Response (276 & 277)
Unsolicited (277)
Health Care Service Review (278)
Health Care Claim (837 & NCPDP Standard)
Health Care Claim Payment and Remittance Advice (835)

NOTE: The standard transaction for the Coordination of Benefits using the 837 is not HIPAA mandated and therefore not currently a requirement for HIPAA compliance.

Health Care Eligibility Inquiry and Response (270 & 271)
A provider uses the 270-benefit inquiry transaction to inquire about Medicaid eligibility for a recipient. Effective October 16, 2003 this will replace the Medicaid Eligibility Verification Systems (MEVS) transaction. It can also be used to check benefits, deductibles, and copays of the patient's health plan and verify that the patient is on file and currently covered by the plan. The 271 is a response from Kentucky Medicaid to the inquiry. The response is conditional. It is not a guarantee of payment.

Health Care Claim Status Inquiry and Response (276 & 277)
A provider uses the 276 claim status inquiry to ask about the status of processing for a particular claim or claims that remain outstanding within its accounts receivable system. The 277 is the response from Kentucky Medicaid.

Unsolicited (277)
Kentucky Medicaid is using this transaction to transmit the status of a suspended or pended claim back to the provider.

Health Care Service Review (278)
This transaction is used to transmit referral information between providers and between provider and payer. Note: A referral from provider to provider is one of the most attractive transactions for providers.

Health Care Claims (837 & NCPDP Standard)
Effective October 16, 2003 health care claims for pharmaceuticals will use the NCPDP v5.1 standard to bill Kentucky Medicaid.

Other claims use the X12 837 format. There are separate Implementation Guides (the official standard) for institutional claims, professional and dental claims. The 837 replaces electronic versions of the uniform billing claim and the CMS 1500. It can carry HMO medical encounter accounting information as well as billing claims. A key consideration for coordination with payer claim systems is a requirement for systems to retain all of the information received on the claim.

Health Care Claim Payment and Remittance Advice (835)
The Payment and Remittance Advice transaction is frequently used in separate functions. In the payment role, it is a payment order directing a bank to effect payment to a provider; in this role, the remittance advice is primarily payment reference information to enable the provider's systems to match up the payment with claims paid. Payments are frequently made in aggregate to cover several claims. In the electronic remittance advice role, it explains payment, partial payment, or denial item by item for each claim. The remittance advice is intended to support automatic reconciliation of claims in provider accounts receivable systems and is one of the most attractive transactions from a provider's viewpoint.

Implementation Guides for the Standards

The implementation guides for the ASC X12N standards may be obtained from the Washington Publishing Company, 806 W. Diamond Ave., Suite 400, Gaithersburg, MD, 20878; telephone: 301-949-9740; FAX: 301-949-9742. These guides are also available at no cost through the Washington Publishing Company on the Internet at http://www.wpc-edi.com/hipaa/.
The implementation guide for retail pharmacy standards is available from the National Council for Prescription Drug Programs, 4201 North 24th Street, Suite 365, Phoenix, AZ, 85016; telephone: 602-957-9105; FAX: 602-955-0749. It is also available from the NCPDP's website at http://www.ncpdp.org.

Medicaid Companion Guides

Unisys and the Department have prepared companion guides for Medicaid Services. The companion guide specifies unique data fields necessary to correctly submit standard transactions for Kentucky Medicaid processing. They are to be used in conjunction with the implementation guides. Companion guides are available on Kentucky Medicaid's website located at http://chs.ky.gov/dms.

Attachments

At this time, claims requiring attachments must still be billed via paper. Each claim is processed separately; therefore, each individual claim will need the required or supporting documentation. Attachments will be handled in the same manner as the current process standard for KY Medicaid.

EOB/Adjustment Reason/Remark Codes

The EOB/Adjustment reason/remark codes will change to HIPAA compliant codes. These codes will be included on ASC X12N835 electronic remit and/or paper remittance advice. The purpose of the EOB/Adjustment Reason/Remark Codes is to communicate the status and disposition of the claim to the provider.

Unisys Technical Support

All Trading Partners are encouraged to utilize EDI rather than paper claims submission. To become a business-to-business EDI Trading Partner contact the Unisys Electronic Data Interchange Technical Support Help Desk at **800-205-4696**.

HIPAA Help Desk

The HIPAA Help Desk will be operational beginning January 1, 2003 through December 31, 2003. If you have a general HIPAA question please call **800 807-1232** between the hours of 8:00am to 6:00pm EST.

Additional Resources:

HRSA HIPAA Website
http://www.bphc.hrsa.gov/hipaa/
DHHS Administrative Simplification Website
http://aspe.os.dhhs.gov/admnsimp/
Centers for Medicare and Medicaid Services (CMS)
http://cms.hhs.gov/hipaa/http://www.cms.gov/hipaa
Southern HIPAA Administrative Regional Process (SHARP) workgroup
http://www.sharpworkgroup.com/
Workgroup for Electronic Data Interchange's (WEDI) Strategic National Implementation Process (SNIP)
http://snip.wedi.org
Washington Publishing Company (Implementation Guides)
http://www.wpc-edi.com